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ABSTRACT

The physical and psychological difficulties which accompany grief resulting from another's death are described, and the intrapersonal and interpersonal communication behaviors exhibited by bereaved individuals are outlined. The role of intrapersonal communication--the mourner communicating with himself--and interpersonal communication--the mourner communicating with others on an informal level--and the therapeutic value of communication concepts for dealing with grief are examined. The rapidly developing study of thanatology--the science of dying--and the emergence of grief therapy groups, in which those who have experienced grief meet with newly bereaved persons, are interpreted as testaments to the importance of communication as the prime variable in this situation. Communication provides a therapeutic catharsis for the mourner and, application of communication concepts in the verbalization of grief can provide a set of labels and information which help the grieved person deal with his problems. Effective intra- and interpersonal communication can ease the pain experienced by the mourners. (LG)

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Communication During Grief

by

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(A paper presented to the International Communication Association Convention -- Therapeutic Communication Session -- Montreal, Canada: April 25-28, 1973)

There are many psychological disorders which are in need of various kinds of therapy, as witnessed by the variety of topics discussed in the topic here, but one of the most widespread and universally experienced psychic disorders in all cultures, but ours especially, is depression following the death of a loved one. Death of a spouse is the single most profound and potent cause of psychological disorder and death of a family member other than spouse ranks third in potency for causing psychological and somatic difficulties. It follows death of spouse and divorce only. Experiencing grief of either one's parent or one's spouse; one's children or one's sibling is highly probable for each of us in this room, if we have not already experienced such an event. Even if we have, it is likely that we will experience that kind of event again before we ourselves "depart" as the mortician so delicately puts it.

In spite of the widespread occurrence of grief experiences and in spite of the profound psychological and physical changes grief can cause, our society knows little about the phenomenon and talks less directly about it than any other subject save perhaps homosexuality. Western Culture, particularly in the United States, has what I call a "Cosmetic

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Approach" to the subject of death. We refer to the "loved one" or the "departed" or the "deceased" or the one who has "passed on" or "passed away" as if our words can soften the features of the fact that the family member -- husband, wife, parent, sibling, or whatever, is dead -- d-e-a-d.

Not only do we tend to use words cosmetically, but we use situations cosmetically: friends of the "Deceased" turn up at the funeral home for "visitation" and after briefly expressing condolences proceed to talk about something else, when at that moment there is nothing else except the fact of death. For some weeks after the funeral, friends use situations to cosmetize the fact of the death experience -- they take the bereaved out to dinner or to a show, or to a concert, and all the while are discrete not to mention facts which might bring back memories of the recent loss and hence tears and that bugaboo of Western Culture emotion. And of course our cosmetic approach to death is nowhere more clearly witnessed than in the rituals of funeral and burial itself. Modern day morticians (they prefer to be called funeral directors) or undertakers take great pains to "redo" the body using all sorts of cosmetic means to make the object appear to be sleeping peacefully in a slightly reverent position. Anyone who has read the book The American Way of Death is familiar with the extremes to which undertakers go to assure success of their cosmetology -- in some cases arranging the corpse in a sitting position in a chair and inviting mourners in with words like "Mrs. Jones will see you now." President Kennedy's body was carried from Parkland Hospital in a white hearse which had music piped in, presumably for the corpse to enjoy.

In short, when it comes to dealing with the subject of death and the grief process, we seem forced to talk about the most "here and now" topic which we will ever face in extremely "there and then" ways. This is further emphasized by the communication behavior of most persons to bereaved individuals, particularly if the person communicating with the bereaved has never experienced this kind of loss himself.

The purpose of this paper is to describe the kind of difficulties which accompany grief (physical as well as psychological) and to outline the kind of intrapersonal and interpersonal communication which accompanies grief. The observations noted here are based on interviews and several studies recently conducted. A second purpose is to outline the kind of communication -- interpersonal mostly -- which can help the mourner and to suggest ways in which our field can help to deal with problems associated with grief. It should be noticed that I have limited the communication with which I am going to deal to intrapersonal -- the mourner communicating with himself -- and to interpersonal -- the mourner communicating with others on an informal level. Grief and death do have public platforms (e.g., the funeral service itself), but I think little can be done to change the kind of communication taking place there, and there may be reasons to allow those forms to remain unchanged.

Intrapersonal Communication And Interpersonal Responses

As in other life experiences, one who experiences the death of a loved one will communicate with himself about that fact -- he will tell himself (many times an hour or a day) that his spouse, parent, or child

is dead; he will ask himself if there was anything that he might have done for the loved one while he was alive or to make his death more comfortable and meaningful; and he will talk to himself about what is happening at that moment to him and about what is likely to happen in the future and how to deal with it. It is in this last area that I wish to concentrate because it is there that most problems occur, largely due to cosmetic approach to death described above. Most persons facing grief for the first time are unaware of the physiological and emotional psychological symptoms which accompany the depression following the death of a loved one. Being unaware of these things, the mourner is afraid of them -- afraid that he is the only one who has ever experienced them; that he is weak; that his faith was paper thin; that he is not standing up well -- not living up to expectations. He is also unaware that his illness -- grief -- has stages and that it is likely to last for some time (anywhere from six months to three or five years -- usually about 18 months for persons aged 30-50). What are the things which happen to the bereaved during the grief syndrome and how "normal" or probable are they?

Physical Symptoms[1]

Just as the body responds to physical damage and shock, so it also responds to psychological shock or damage.

- Over 95% of grief stricken persons experience some kind of sleep disturbance -- they may dream of the

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[1]Recognizing The Depressed Patient by Frank Ayd, p. 26.

loved one; they may awake and "see" visions of the loved one; they may have difficulty going to sleep.

- 80% experience constipation and/or urinary frequency -- some have diarrhea.

- Over half experience nausea, irregular heartbeat or other cardiovascular disturbances. There are usually sexual disturbances -- decreased or increased libido or menstrual changes (e.g., some women may cease menstruating or may begin again if after menopause -- blood flow may occur without ovulation.

- Most persons experiencing this kind of depression find themselves awakening early (80%) and feeling depressed -- at first for an hour or so and in later stages for more extended periods of time.

- There is usually weight gain or weight loss.

It is interesting to speculate about the causes of these physical changes: perhaps the mourner feels a necessity to either symbolically engage totally with life functions (increased appetite, increased libido, renewal of ovulation) or to symbolically disengage from life functions (e.g., loss of appetite, constipation, decreased libido, etc.).

Quite clearly, these physical effects are not thought of as 'normal;" experiencing them, especially in the psychological state of shock bereaved individuals find themselves in, is bound to be frightening. Thus not only does the bereaved individual find himself talking to himself about his loss, but he is also likely to find himself talking to himself about his physical abnormalities -- wondering whether they are psychosomatic or if they will go away or in unfortunate instances that he is going crazy, having a breakdown or falling apart. The phrases uttered by bereaved often reflect this kind of dissonance -- "I don't know if I can manage" "Sometimes I think the world is just not worth it" "I don't

know how other people can bear up so well" all of which are pleas from the intrapersonal self for interpersonal comfort and reassurance. In terms of internal physical disorders associated with grief, we need to provide the bereaved with knowledge that their physical complaints are common and are not the result of a disordered mind -- in Harris' terminology we need to let him know that his physical "not OKness" is expected and is normal or "OK."

Emotional Disorders[2]

In addition to the physical complaints cited above, the bereaved individual experiences the onset of disturbing emotional states. He is likely to communicate with himself about these also, but more often he will discuss these with other persons -- they seem more acceptable than the physical disorders described earlier and are thus easier to discuss with other persons.

- Nearly 100% of bereaved persons experience feelings of sadness and low spirits.
- 80% experience guilt, hopelessness and feelings of futility.
- 75% find themselves edgy and easily irritated.
- 70% cry often.
- In 60% of bereaved depressions there is a fear of dying oneself or of contracting the disease or malady which killed the loved one.

The classic case recently is the "sympathy pains" felt by Bill Moyers just after the death of Lyndon Johnson causing him to be hospitalized for

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[2] Ibid., p. 51.

chest pains. Only recently have we investigated this phenomenon, but there is such a thing as the "Broken Heart Syndrome" -- persons experiencing the death of a loved one die five times more often in the year following the loss than control group persons; the rate is 12-1 among widows and widowers and 24-1 for widowers alone. [See Death As A Fact Of Life by David Hendin (W. W. Norton and Company, Inc., 1973) -- my references are from a series of synopses reported in the DeKalb Daily Chronicle, February 27-March 5, 1973. This particular reference is from the March 5, 1973 issue, p. 10].

Psychic Complaints[3]

I have been just describing a set of emotional disorders which occur during grief (feelings of a particular emotion such as guilt or futility.) There is another kind of psychic complaint which occurs during the depression following the death of a loved one -- Dr. Frank Ayd calls this kind of complaint psychic in nature -- it does not so much reflect a particular emotion but instead reflects a particular state of mind for the bereaved.

- 90% of persons report that they have poor concentration and that morning is the worst time of day for them. Friends who seek to comfort the bereaved usually assume that long evenings are difficult and so entertain at night -- we need to encourage interpersonal comfort in mornings.

- 80% of persons suffering grief depression report that they have no interest in anything and that they cannot get involved with anything. Even reading a magazine is impossible.

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[3]Ayd, p. 70.

- 80% have great difficulty making decisions -- first deciding and then changing their minds, sometimes to the dissatisfaction of friends and relatives trying to offer advice and comfort.

- 60% of persons have poor memory. They lose such essentials as car keys, check books, etc. Again perhaps there is a symbolic desire to disengage from living and its symbols. This loss of memory is particularly frightening.

In almost all cases these symptoms fluctuate widely in intensity and duration. Bereaved often report that their physical and emotional complaints come over them "in waves" or some similar metaphor.

Communication and Grief Therapy

Dr. Alfred Weiner of New York's Montefiore Hospital, studied a group of bereaved individuals during the first year after their loved one had died. He concluded from this study that " . . .one of the major problems with bereavement is a lack of social involvement with another human being. . . . The best thing you can do for a bereaved person is to talk about the dead person."[4] Hendin in his book Death As A Fact Of Life reiterates this conclusion and describes the kind of interpersonal communication which should occur in attempts to comfort bereaved persons. He says

> The bereaved can review the experiences shared with the deceased. Talking out the situation helps the individual experience his loss. At the same time it is possible for a friend or relative to encourage too much discussion. The bereaved may indicate that there has been enough talk for a time. If this happens, an understanding person should recognize that what the bereaved may really need is the comforting presence of someone who cares.

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[4]Hendin, DeKalb Chronicle, March 5, 1973, p. 10.

One of the more recent and exciting approaches to communicating with bereaved persons is the use of groups, such as those now operating in Minneapolis (T.H.E.O. - They Help Each Other) in which persons who have experienced grief meet with newly bereaved persons. The major portion of persons in this group are widowers or widows, though the group sponsors communication sessions for others as well. The group started modestly -- Bethlehem Lutheran Church volunteered its facilities for meeting times for non-denomenational meeting sessions for anyone who was widowed to meet and discuss their experiences. Reverend Smith, the assistant pastor of the church, assisted by discussing some of the common physical and psychological complaints in grief as well as some of the spiritual aspects of death. This introductory discussion usually lasted 10 minutes or less. Persons then met and discussed with one another. At the initial T.H.E.O. meeting three persons gathered, but this soon grew to 80 or 100 at each meeting. The procedures became much more sophisticated also -- participants were divided into groups according to the stage in the grief process which they were experiencing; older members of the organization served as communication facilitators by explaining the particular grief stage and its characteristic problems and then by encouraging communication; and the group and its leadership began serving various constituencies -- similar groups were established for persons experiencing divorce and emotional problems. Ultimately, T.H.E.O. served 800-1,000 in its first year. Later The Wilder Foundation of St. Paul, Minnesota, took over sponsorship of the group and it continues in service there. Several branch groups

have been started to serve various sections of both of the Twin Cities.[5]

The interesting thing suggested by the success of T.H.E.O. is that the prime variable in dealing with grief is communication -- virtually 100% of the persons attending the T.H.E.O. sessions reported that no one had told them of the kinds of physical problems they might expect to encounter and that they had repeatedly questioned their own ability to handle grief problems. The need for communication settings and facilitators aware of the problems relating to depression and grief is surely a signal to our field to devise seminars and other formats for bereaved persons. Research questions in the area are obvious ("Why do widowers die more frequently than widows in the year following loss of spouse?" "How do children, who are relatively limited in their communication concepts and vocabulary, deal with the loss of a parent?" and others) and are likely to be funded by such organizations as the National Institutes for Mental Health. This spring a six day seminar will be held at Northern Illinois University which will focus on various aspects of death including grief. Enrollment thus far is projected to be high and will include funeral directors, who need and want to know what they can do besides run a funeral, nurses and doctors who counsel the dying and the survivors, bereaved, and persons who have not yet experienced death. The rapidly developing study of thanatology -- the science of dying -- attests to interest in the topic.

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[5]All information related to T.H.E.O. is from interviews with Ms. Beverly Thomas and Ms. Phyllis Engel, both of whom served in various capacities on the T.H.E.O. governing boards etc.

All of these facets of grief revolve around communication concepts for communication in most therapeutic situations serves two functions: catharsis for the disturbed person and it can provide a set of labels and information which give the disturbed person a set of categories with which to deal with his problems. The first and last lines of Robert Anderson's play "I Never Sang For My Father" point out that "Death ends a life, but it does not end a relationship, which struggles on in the survivor's mind towards some resolution which it never finds." Though the resolution may never be found, sound intra and interpersonal communication can ease the pain and can be therapeutic.